

conducted in a primary care setting with patients newly prescribed co-amoxicillin for 3 up to 14 days. Community pharmacies are randomized to intervention or control group, they recruit patients and provide the app-based service. All participants use the TOM medication management app to track antibiotic intakes, keep a written symptom diary and evaluate their well-being on a 5-point smiley scale. In addition, the intervention group receives medication intake reminders and two types of text messages (educational and motivational) delivered via smartphone. At the end of therapy, adherence counseling is delivered by phone to all participants by the study team to discuss the recorded data (adherence, symptoms, well-being). An online survey is conducted to assess patient satisfaction with the service including the app. Based on the literature, the sample size was calculated with an anticipated 22% improvement in taking adherence, resulting in 58 patients per group (116 patients in total). The primary outcomes are adherence rates, including taking, dosing, and timing adherence. Secondary outcomes include persistence rates, dose-to-dose intervals, time to symptom resolution, time to well-being, the number and severity of symptoms categorized as adverse events, and overall satisfaction of patients and providers with the service. For analysis, both groups will be compared across all primary and secondary outcomes. The study has been approved by the local ethic committee and will be completed by December 2024.

Findings: Currently, 56 pharmacies agreed to participate and have recruited a total of 33 patients with an equal distribution between both study arms (Intervention: 16; Control: 17). Final study results will be presented at the conference.

Conclusion: n.a.

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Co-creation approach to adapting and implementing an interprofessional service targeting initiation adherence in Switzerland: myCare Start –Implementation Science project

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Background: The New Medicine Service (NMS), developed in the UK, was effective in improving medication adherence among patients initiating long-term medications. However, international scale up of this complex intervention has highlighted the need for meaningful intervention adaptation to address contextual differences and implementation barriers in new healthcare settings.

Purpose: Guided by the O' Cathain et al. (2019) Framework for intervention development and the ADAPT Guidance, the myCare Start –Implementation project (myCare Start-I) utilised a co-creation approach supplemented by contextual information, known theory and empirical evidence to adapt the NMS, developing a contextually fitting myCare Start service model for use within the ambulatory primary care medicine and community pharmacy setting in Switzerland.

Method: The co-creation process involved an exploratory qualitative approach, including repeated semi-structured focus groups with stakeholders (patients, physicians, and pharmacists) and consensus-based workshops with investigators to iteratively refine the intervention. An initial context analysis identified 63 contextual factors impacting intervention design or implementation of myCare Start in Switzerland. A panel of interprofessional investigators including primary care physicians and end-user representative (n=15) prioritised these factors,

assessing both the importance of addressing each factor and the confidence that it could be addressed in the Swiss context. The resulting priority areas formed the focus of repeated semi-structured stakeholder focus groups to discuss solutions and possible service adaptations. This iterative process culminated in 12 proposed adaptations of the original NMS intervention which were presented to the investigative team and assessed based on acceptability to Swiss context.

Findings: A total of 12 stakeholder focus groups (n=50 stakeholders) and two investigator consensus workshops led to a final list of seven selected intervention adaptations. Adaptations were mapped in accordance with the Framework for Reporting Adaptations and Modifications Expanded (FRAME). Adaptations occurred at both individual (e.g., flexible delivery modes, extended follow-up timeline, pharmaceutical device demonstration options, inclusion of support persons) and organizational levels (e.g., physician referrals to myCare Start, standardized pharmacist feedback to physicians and greater guidance for interventions to assist patients).

Conclusion: The co-creation process, as part of a multi-strategy intervention adaptation process successfully produced a contextually appropriate myCare Start model tailored to the needs of Swiss stakeholders. These adaptations are anticipated to enhance fit for the context, recipient and provider alignment, service feasibility, engagement and cultural relevance, that hopefully, will translate to improved intervention and implementation outcomes when the service is evaluated in a Type II hybrid effectiveness-implementation trial in 2025.

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Attitudes of Patients with Solid Tumors Towards Deprescribing Non-Cancer Medicines and Proton Pump Inhibitors

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Background: Proton pump inhibitors (PPIs) may reduce the effectiveness of systemic cancer treatments by altering the gut microbiome, emphasizing the importance of deprescribing inappropriate non-cancer medicines, including PPIs, to potentially improve survival outcomes.

Purpose: To assess the attitudes of patients with solid tumors towards deprescribing non-cancer medicines and PPIs.

Method: A cross-sectional study used the Slovenian version of the revised Patients' Attitudes Towards Deprescribing (rPATD) questionnaire, adapted for PPI use with additional questions about pharmacists' roles. The rPATD, using a Likert scale from 1 to 5, was completed by patients using PPIs before oncology consultations or during systemic cancer treatment in a hospital. The study evaluated the proportion of patients with solid tumors willing to stop non-cancer medicines and PPIs based on doctors' or pharmacists' advice and identified influencing factors.

Findings: Among 128 patients with cancer prescribed PPIs, 75 (58.6%) were female, with a median age of 66 years (IQR 16). Most had upper gastrointestinal (38; 29.7%), gynecological (29; 22.7%), thoracic (27; 21.1%), or lower gastrointestinal cancers (17; 13.3%). Patients reported taking a median of 3 non-cancer medicines (IQR 3).

The rPATD factor scores indicated a perceived medication burden (median 2.8, IQR 1.0), belief in medication appropriateness (median 3.4, IQR 1.0), concerns about stopping medicines (median 2.8, IQR 0.8), and high involvement in medication management (median 4.3, IQR 0.8).

A high willingness to deprescribe non-cancer medicines based on a doctor's advice was observed (89.9%), while willingness to deprescribe PPIs was lower (79.9%). Logistic regression indicated that older age (OR 1.05, CI 1.00–1.10; p 0.036), greater involvement in medication management (OR 3.13, CI 1.31–7.49; p 0.010), and fewer concerns about stopping PPIs (OR 0.36, CI 0.14–0.93; p 0.036) were associated with increased willingness to deprescribe PPIs on a doctor's advice.

Fewer patients were willing to deprescribe non-cancer medicines (45.3%) or PPIs (36.7%) on a pharmacist's advice. Older age was associated with willingness to